US Family Health Plan
Prior Authorization Request Form for
mirabegron **(Myrbetriq),** vibegron **(Gemtesa)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 Please complete the clinical assessment:

1. Does the patient have a confirmed diagnosis of overactive bladder with symptoms of urge incontinence, urgency, and urinary frequency?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Has the patient tried and failed behavioral interventions, such as pelvic floor muscle training in women and bladder training?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Has the patient had a 12-week trial of TWO of the following: tolterodine extended-release (Detrol LA), oxybutynin IR, oxybutynin ER, or trospium immediate-release (Sanctura immediate-release) and failed due to a treatment failure or intolerable adverse effects?	☐ Yes Proceed to question 5	☐ No Proceed to Question 4
4. Has the patient experienced central nervous system (CNS) adverse effects with an oral overactive bladder (OAB) medication or is at increased risk for CNS adverse effects due to comorbid conditions or other medications?	☐ Yes Proceed to question 5	☐ No **STOP** **Coverage not approved**
5. Is the patient's creatinine clearance (CrCl) LESS THAN 15 mL/min?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question 6

Continue on next page

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6. What is the requested medication?	☐ Myrbetriq - Proceed to question 7 ☐ Gemtesa - **Sign and date below**	
7. Is the patient's creatinine clearance (CrCl) GREATER THAN 29 mL/min?	☐ Yes **Sign and date below**	☐ No Proceed to question 8
8. Does the daily dose of the requested medication EXCEED 25 mg?	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____

[27 January 2021]